

Patient Name:

Birth Date:

Date Created:

General

Who is your primary care physician?

 Yes No

If yes

How would you rate your general health?

 Excellent Good Fair Poor

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

 Yes No

If yes

Are you on a special diet?

 Yes No

If yes

Do you use any controlled substances?

 Yes No

If yes

Do you use tobacco or nicotine?

 Yes No

If yes

Do you smoke or vape?

 Yes No

Do you frequently get cold sores/fever blisters?

 Yes No**Women: Are you...**

Pregnant/Trying to get pregnant?

 Yes No

If yes

Nursing?

 Yes No

Taking oral contraceptives?

 Yes No**Allergies**

Are you allergic to any of the following?

 Aspirin
 Codeine
 Fluoride
 Iodine
 Local Anesthetics
 Milk
 Red Dye
 Tetracyclin Chlorhexidine (CHX)
 Erythromycin
 Fruit
 Latex
 Metals
 Nuts
 Sulfa

Other

If yes

Please list any medications or vitamins you are taking, with dosages.

Medical History

Do you currently have, or ever had?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	ADD/ADHD	<input type="radio"/> Yes <input type="radio"/> No	Anemia	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Arthritis or Gout	<input type="radio"/> Yes <input type="radio"/> No	Blood Disorder/Disease	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Digestive or Eating Disorders	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No
Heart Problems or Cardiac Stent	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	High or Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Infective Endocarditis	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease or Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Neurologic Disorders	<input type="radio"/> Yes <input type="radio"/> No	Orthoedic or Soft Tissue Implant	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis/Osteopenia	<input type="radio"/> Yes <input type="radio"/> No
Psychiatric Treatment	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatment	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No	Seizures or Epilepsy	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Sleep Disorders	<input type="radio"/> Yes <input type="radio"/> No	STI/STD/HPV	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No	Trouble Hearing/Hearing Aid	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Ulcers	<input type="radio"/> Yes <input type="radio"/> No	Viral Infections	<input type="radio"/> Yes <input type="radio"/> No		

Have you been diagnosed with Autism/Autism Spectrum Disorder?

 Yes No

If yes

Any additional Comments?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient, Parent or Guardian:

X

Date: _____